

**Welcome. Please tell us a little about yourself.**

**Patient Registration**

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Primary Care Doctor: \_\_\_\_\_ Phone # \_\_\_\_\_

Name (last, first, middle): \_\_\_\_\_ Marital Status: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone # (\_\_\_\_) \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_ Cell # (\_\_\_\_) \_\_\_\_\_

Sex: M or F Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ e-mail: \_\_\_\_\_

SS # \_\_\_\_\_ (Check One) ☐ Employed ☐ Retired ☐ Student ☐ Other \_\_\_\_\_

Race: \_\_\_\_\_ Language: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

**Emergency Contact**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

**Insurance Information.**

Insurance Company: \_\_\_\_\_

Subscriber (Check One) ☐ Self ☐ Spouse ☐ Parent ☐ Other \_\_\_\_\_

Name of Subscriber (if other than patient) \_\_\_\_\_ DOB: \_\_\_\_\_ SS# \_\_\_\_\_

Policy ID # \_\_\_\_\_ Group # \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_

**Please inform us if you have Vision Service Plan (VSP). Yes or NO**

I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine benefits.

I acknowledge receipt of Lakeland Ophthalmology's Notice of Privacy Practices.

I request that payment of authorized insurance/Medicare benefits be made on my behalf to Lakeland Ophthalmology and/or Lakeland Optical for all assigned claims. I request that payment of authorized insurance/Medicare benefits not assigned be made either to me or on my behalf to Lakeland Ophthalmology and/or Lakeland Optical for any services furnished me by that supplier.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_